STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING 00 B. WING	09/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: September 12, 13, 14, 15, 16, and 19, 2011 Facility number: 000116 Provider number: 155209 AIM number: 100266330 Survey team: Janie Faulkner, RN-TC Diana Sidell, RN Penny Marlatt, RN (9/12, 9/13, 9/15, 9/16, 9/19, 2011) Census bed type: SNF/NF 92 Total: 92 Census Payor type: Medicare 14 Medicaid 68 Other 10 Total 92 Sample: 19 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	REQUEST OFR PAPER COMPLIANCEThe Waters of Clifty Falls would like to request paper compliance for the annual Recertification and State Licensure Survey dated September 19, 2011. We appreciate your consideration in this matter.Thank you,Becky Shinn, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on September 26, 2011 by Bev Faulkner, RN			

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F0203 SS=D	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone			

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	number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.			
	Based on interview and record review, the facility failed to provide written notice for discharge from the facility 30 days or more prior to discharge from the facility. This deficient practice affected 1 of 2 residents reviewed for discharge in a sample of 19. (Resident #100) Findings include: Resident #100's clinical record was reviewed on 9-16-11 at 9:57 a.m. His diagnoses included, but were not limited to, depression, hypertension (high blood pressure), obesity, diabetes, COPD (chronic obstructive pulmonary disease or lung problems), BPH (benign prostatic hypertrophy or prostate problems), CAD (coronary artery disease or heart problems), and degenerative disc disease (back problems). Review of the Social Services notes indicated on 6-30-11, the previous Social Services Designee (SSD) met with the	F0203	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulation and to continue to provide quality care.F203 Notice requirements before transfer/dischargeIt is the intent of this facility to provide written notice for discharge from the facility 30 days or more prior to discharge from the facility.1. ACTION TAKEN:A. In-serviced all nursing and social services staff in regards to providing 30 days or more written notice prior to discharge from the facility.2. OTHERS IDENTIFIED:A. 100% audit of all discharges in the last three months. No other residents were identified.3. SYSTEMS IN PLACE:A. All potential discharges will be reviewed in the daily QA stand up meeting by the IDT. Review for 30 day written notice of discharge and discharge plan of care.4. HOW MONITORED:A. The IDT will monitor/review all potential	10/05/2011

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	resident and indicated, "he will be ready for discharge in August." Another Social Services notation, dated 7-14-11, indicated a care plan meeting was held with the resident's family. It indicated, "Res [resident] suppose [sic] to be out of facility by 8-8-11. Business office will appeal info from [name of agency]. Res [resident] will be out by 8-8-11, if not approved to stay." In interview with the current SSD on 9-16-11 at 11:50 a.m., she indicated she became employed at the facility on 7-5-11. She indicated she could not address any discharge planning prior to that date. She indicated she was present at a meeting, date not indicated, in which the resident, a family member of the resident, the Administrator, a member of the Business Office and "some others," unidentified, were present and "discussed requesting a Medicaid extension and what the plan was if it wasn't approved." She indicated, "I made sure they [the resident and family member] understood he was approved through Medicaid just through 8-8-11," when I returned in July. She indicated the extension was granted for the time period 8-8-11 to 9-7-11. She did not indicate a notice for discharge was provided for the tentative August 2011 discharge.		resident discharges in the daily QA stand-up meeting to ensure 30 day notice pror to discharge.B. CEO/Designee will review all dischages to ensure 30 days notice has been given.C. All discharges will be reviewed in quartly QA meeting with Medical Director to review for concerns with discharge.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: October 5th, 2011.	

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	A document entitled, "Notice of Transfer or Discharge, " also noted as, "State Form 49669" was dated "9-5-11", 3 days prior to Resident #100's discharge date. The date of 9-5-11 was listed in two locations on the document. A copy of a policy entitled, "Resident Rights," was provided by the Director of Nursing on 9-13-11 at 9:00 a.m. This document indicated, under the heading "Admission, Transfer and Discharge Rights, "the notice of transfer or discharge required...must be made by the facility at least thirty (30) days before the resident is transferred or discharged." 3.1-12(a)(7)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure medically-related social services for a resident with a history of sexual misconduct. This deficient practice affected 1 of 13 residents reviewed for medically-related social services. (Resident #100) Findings include:	F0250	F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICEIt is the intent of this facility to have Medically related social services for a resident with a history of sexual misconduct.1. ACTION TAKEN:A. All nursing staff and social services were in-serviced on appropriate medically related social services for and concerning any resident with an identified history of secual misconduct.2. RESIDENT'S	10/05/2011

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	Resident #100's clinical record was reviewed on 9-16-11 at 9:57 a.m. His diagnoses included, but were not limited to, depression, hypertension (high blood pressure), obesity, diabetes, COPD (chronic obstructive pulmonary disease or lung problems), BPH (benign prostatic hypertrophy or prostate problems), CAD (coronary artery disease or heart problems), and degenerative disc disease (back problems). Additionally, in an interview with the Administrator on 9-16-11 at 2:20 p.m., he indicated Resident #100 was identified as a child sexual predator. Review of the social services notes did not indicate any reference to Resident 100's history of a child sexual predator, except for a hand written note, dated August 4th (no year), that indicated only one particular area shelter would accept male sexual offenders. Review of the "MDS 3.0 Social Service Progress Note: Resident Interview" form, dated 6-15-11, it indicated, under Section Q, "Psychoactive Medications & Diagnoses to Support," a slash mark to indicate "none.". In interview with the current Social Services Designee on 9-16-11 at 11:50 a.m., she indicated she was aware he was re-admitted to the facility some time in		IDENTIFIED:A. 100% audit of all current residents for a history of sexual misconduct. No other residents were identified.3. MEASURES TAKEN:A. All nursing staff and social services staff were in-serviced on appropriate medically related social services with an identified history of sexual misconduct and the appropriate interventions to be taken.4. HOW MONITORED:A. Social Service Director/Designee will audit/review all potetial admissions to review for any history of sexual misconduct; if any are identified, appropriate interventions will be put into place immediately.B. CEO/Designee will review all admission audits as completed during QA morning stand-up meeting; and any identified concerns will be reviewed with Medical Director @ the QA quarterly meeting.5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of compliance is: October 5th, 2011.	

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	June [2011], "something related to [being] a sexual predator." She indicated she became employed at the facility in July 2011. She indicated she was unaware of anything related to care planning in relation to the sexual predator issue. She indicated she was aware "the charges were child related, but no specifics." A job description for the position of "Director of Social Services," was provided by the Director of Nursing on 9-16-11 at 3:31 p.m. This job description indicated, "Demonstrates knowledge of age specific developmental factors specific to adult and geriatric residents (i.e. physical, cognitive and socialization factors)...Maintains significant social service progress notes on the resident's medical chart...Counsels residents regarding psychosocial programs." 3.1-34(a)			

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F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure the Minimum Data Set Assessment (MDS) accurately reflected a resident's current status for one resident who received dialysis and one resident with a diagnosis of depression and receiving an antidepressant. This affected 2 of 17 residents reviewed for accuracy of MDS assessments in a sample of 19. (Resident #80 and #100)	F0278	F278 RESIDENT ASSESSMENT:It is the intent of this facility for the Minimum Data Set Assessment to accurately reflect a resident's current status, including dialysis and a diagnosis of depression.1. ACTION TAKEN:A. In regards to Resident #80: the assessment was updated to reflect the resident receiving dialysis.B. In regards to Resident #100: the assessment was updated to reflect the resident having a diagnosis of Depression and recieving an	10/05/2011

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	Findings include: 1. Resident #80's record was reviewed on 9/15/11 at 4:35 p.m. The record indicated Resident #80 was admitted with diagnoses that included, but were not limited to, end stage renal (kidney) disease, seizures, and insulin dependent diabetes mellitus. Physician's orders, dated 8/6/11, indicated Resident #80 was to receive hemodialysis 3 times a week, on Monday, Wednesday, and Friday. An admission MDS, dated 8/12/11, failed to reflect this resident received the treatment of dialysis. During an interview on 9/16/11 at 3:18 p.m., LPN #1/MDS Coordinator indicated the MDS should have reflected the resident was receiving dialysis. 2. Resident #100's clinical record was reviewed on 9-16-11 at 9:57 a.m. His diagnoses included, but were not limited to, depression, high blood pressure, obesity, diabetes, chronic obstructive pulmonary disease (lung problems), benign prostatic hypertrophy (prostate problems), coronary artery disease (heart problems), and degenerative disc disease		antidepressant.2. OTHERS IDENTIFIED:A. 100% audit of all residents for appopriate assessment and inclusion of all current diagnosis', medications and treatment.3. MEASURES IN PLACE:A. All nurses were educated/in-serviced on complete and accurate assessments.4. HOW MONITORED:A. MDS Coordinator/Designee will review each assessment for accuracy prior to completing MDS.B. IDT will monitor/review all admission MDS assessments as completed in daily QA stand-up meeting for accurancy.C. Admission MDS audits will be reviewed in quarterly QA meeting with Medical Director.5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: October 5th, 2011.	

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	(back problems). Additionally, in an interview with the Administrator on 9-16-11 at 2:20 p.m., he indicated Resident #100 was identified as a child sexual predator. Resident #100 's diagnosis of depression was not reflected under Section I (Active Diagnoses) of his discharge Minimum Data Set (MDS) assessment, dated 9-9-11. The resident's "Post Discharge to Home Instructions" document indicated he received Imipramine (a tricyclic antidepressant) 20 milligrams every 8 hours. Review of the "MDS 3.0 Social Service Progress Note: Resident Interview" form, dated 6-15-11, it indicated, under Section Q, "Psychoactive Medications & Diagnoses to Support," a slash mark to indicate "none." An active care plan, dated 6-6-11, indicated this resident had a diagnosis of depression and received an antidepressant. On 9/19/11 at 12:45 p.m., LPN #1/MDS Coordinator indicated they didn't have a specific policy and procedure for MDS Assessments; they use the Resident Assessment Instrument (RAI). 3.1-31(g)			

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F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop or update comprehensive care plans that met residents needs in that: - 4 residents failed to have a care plan that addressed antidepressant use (Residents #74, 92, 64) - 1 resident failed to have a care plan that addressed antipsychotic use (Resident #59) - 1 resident failed to have a care plan	F0279	F279- DEVELOP COMPRHENSIVE CARE PLANSIt is the intent of this facilty to develop and update comprehensive care plans that meet residents needs including: antidepressants, antipsychotic use, fall interventions, anticoagulant use, discharge planning and psychiatric referrals.ACTION TAKEN:A. Regarding resident # 74:The care plan was revised to include the use of an antidepressant, monitoring for side effects and gradual dosage reduction when	10/05/2011

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	update after a fall (Resident #92) - 3 residents failed to have a care plan for anticoagulant use (Resident #92, 64) - 1 resident failed to have a care plan for discharge planning, and had no care plan for psychiatric referral (Resident #100) This affected 5 of 17 residents reviewed for comprehensive care plans in a sample of 19. Findings include: 1. Resident #74's record was reviewed on 9/15/11 at 9:30 a.m. The record indicated Resident #74 was admitted with diagnoses that included, but were not limited to, anxiety, dementia with behavior disturbance, and depression. Physician's orders, dated 9/2011, indicated an order for Paxil (antidepressant) 10 milligrams by mouth twice a day, with a start date of 3/19/11. Medication Administration Records (MARs) for June, July, and August 2011 indicated the Paxil had been given twice a day every day. MARs dated September 1 through September 18 indicated the Paxil had been given twice a day. Care plans with a last review date of 7/18/11 failed to indicate a care plan that		indicated.B. Reguarding Resident # 59:The care plan was revised to include the use of antipsychotic, monitoring for side effects and gradual dosage reduction when indicated.C. Regarding Resident # 92:This resident is no longer at the facility.D. Regarding Resident # 64:The care plan was revised to include use of the antidepressant, monitoring of side effects, and gradual dosage reduction when indicated. The care plan was also revised to reflect the use of Aspirin, monitoring of side effects, and potential for complications.E. Regarding Resident # 100:This resident is no longer at the facility.2. OTHERS IDENTIFIED:A. 100% audit of all resident care plans by the MDS Coordinator/Designee to ensure all current residents have care plans for use of antidepressants, antipsychotics, anticoagulants; which include monitoring of side effects, and gradual dose reductions as indicated.B. SSD/Designee will complete 100% audit of all residents for an appropriate discharge care plan, and a psychiatric referral care plan as needed. Any identified will have an appropriate care plan revision.C. AD/Desingee will complete a 100% audit of all residents for a need of 1 on 1 activities. All identified will be placed on a 1on 1 program.3. MEASURES IN PLACE:A. All nursing staff were	

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	addressed the use of the antidepressant, side effects to monitor, and gradual dosage reductions when indicated. During an interview on 9/19/11 at 2:42 p.m., LPN#1/MDS Coordinator indicated the resident did not have a care plan for the use of the antidepressant. 2. During record review for Resident #59 on 9/16/2011, the record indicated she was admitted with, but not limited to, chronic obstructive pulmonary disease, chronic pain, mood disorder, panic disorder, and peripheral neuropathy.		in-serviced on care plans and interventions to care appropriately for the residents.4. HOW MONITORED:A. MDS/Designee will audit all resident care plans quarterly for inclusion of care plans for medication, interventions, attempted reductions and monitoring. This will be an on-going process.B. CEO/Designee will review all audits as completed in daily stand-up meeting to ensure apprpriate care plans have been put in place with appropriate goals and interventions. This will be an on-going process.C. The D.O.N./MDS/Designee will monitor all care plans quarterly and prn to ensure all are initiated and updated with appropriate goals and interventions. This will be an on-going process.D. All audits will be reviewed with the Medical Director at the quarterly QA meeting for further recommendations.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: October 5th, 2011.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #59's medications included, but are not limited to Seroquel 100 mg once a day -panic disorder, Seroquel 200 mg daily at bedtime -panic disorder, Clonazepam 0.5 mg 1 tablet three times daily no diagnosis for use, Citalopram HBR 20 mg, 1 tablet two times daily - Depression, and Bupropion HCL XL 150 mg 1 tablet once daily - Depression. "Review of MDS 3.0 Social Service Progress Note: Resident Interview," dated 8/29/11, indicated the Mood Section "no issues at this time", the Behavior Section "none, Psychoactive Medications & Diagnoses to support: "Seroquel - panic disorder, Celexa - Depression" "Care plans for above Dx[diagnoses] in place." Care Plan for Resident #59 includes Problem onset 11/29/2010, "I have a dx of depression & require the need to stay active to prevent further decline in my mood...." "*I will show no decline in mood AEB [as evidenced by] decline in ind. [individual] act. [activity] level TNR[through next review]", Approaches: "* I want staff & peers to initiate conversation with me as frequently as possible.... Dated 12/3/10." Care Plan Problem: "I have a rash to my trunk and have c/o [complained of]			

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	itiching [sic]", "*Rash will improve weekly", Approaches: "* I will have antihistamines per order....*antidepressant per order 12/17/10" was added to care plan with no initials. Another care plan "Problem onset 10/05/2010 I have dx; depression AEB tearfulness, *My signs and symptoms of depression will be easily redirected 5-10 min [minutes] after interventions, "Provide my anti-depressant per order" handwritten above typed list of approaches without date/time or initials. "*Provide my antipsychotic per order, *Staff will monitor for drowsiness, headaches, and somnolence".... the care plan approaches failed to include gradual dose reduction attempts for any of psychoactive medications. 3. Review of Resident #92's record on 9/15/2011 at 12:00 p.m., indicated the resident was admitted with, but not limited to Frontal lobe stroke, valvular heart disease, new onset seizures, diabetes type 2, severe pulmonary hypertension, and cerebral arteriosclerosis. Resident #92's medications included, but were not limited to Digoxin 125mcg, once daily, Lasix 40 mg, once daily and Lasix 20 mg, at 4pm daily, Dilantin 100mg, 2 capsules every morning and Dilantin			

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	100mg 3 capsules daily at bedtime, Coumadin 2.5mg, 1 tab at 7pm on Mondays, Coumadin 3mg, 1 tab at 7pm on Sunday, Tuesday, Wednesday, Thursday, Friday, and Saturday. Review of the care plans for Resident #92 indicated, a Problem onset: 8/25/2011, "I am feeling down, depressed, or hopeless" Goal & target date: *I will decrease my symptoms of depression and *I will report increased pleasure in participating in activities", approaches: "*1:1 visits with me", "*Activities to visit with me and provide brief opportunities for me to share in common activity", "*Refer me to a psychological counseling/mental health specialist". Interview with Employee #4/Activity Assistant on 9/15/2011 at 8:30 a.m., regarding which residents receive 1:1 activities and where are those records and she stated, "here is the book that shows who gets 1:1 activities and when." "We don't do 1:1 activities with residents on TCU[transitional care unit], because they have lots of visitors and they have therapy." Resident #92 was not on the list of residents to have 1:1 activity visits. On 9/18/2011 at 6:55 p.m., during a telephone interview with Resident #92's daughter, she indicated that her mother			

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	did not have any stimulation, in a room by herself and they could only visit twice a week, she went one day and her sister went on the weekend to visit. She stated, the Activity Director, said if I had known she wasn't getting enough stimulation I could have had someone to do 1:1 visits, that was the day I went to the facility to tell them she would not be coming back there." Resident #92 was transferred from the facility to local hospital and admitted with Dilantin level of 24.4 on 9/15/2011, the daughter stated, "the doctor at the local hospital said she had Dilantin toxicity and pneumonia from inactivity." Interview with the Social Services Director/Activities Director on 9/19/2011 at 10:30 A.M., regarding new order for Paxil, antidepressant started on 9/14/2011, and she stated "I was doing her 30 day assessment and noticed she was lethargic and depressed, so I asked the nurse to call and get an order for something for depression." Discussed other medications Resident #92 received, such as Dilantin, Coumadin, Lasix, Digoxin which could have been interacting with each other causing lethargy. Discussed 1:1 activities as approach for this resident and Social Services/Activity Director, stated, "I would have if I knew she needed them."			

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Care plan problem onset: 8/19/2011, "I have the potential for skin discoloration r/t[related to] use of Coumadin, asa; * I will have no skin discoloration daily tnr[through next review]; approaches "*weekly and prn[as needed] skin checks, *Analgesic per order, *Anticoagulant per order, *PT/INR per order, *Notify md and family prn."

Care Plan problem onset: 8/19/201, "I am at risk for falls r/t new surroundings, dx; cva, weakness, intermittent confusion, unsteady gait/balance, Goal "*I will have no falls tnr", Approaches"*Call light in reach, *keep paths free from clutter, *Working with therapy, * PRN pharmacy to review meds, *Notify md and family of any falls, *Cue to ask for assist with ambulation/transfers." The fall care plan was not updated with new interventions, after the resident fell on 9/2/2011.

4. Review of Resident # 64's clinical record on 9-15-11 at 10:40 a.m., indicated her diagnoses included, but were not limited to coronary artery disease (heart problems), hypertension (high blood pressure), diabetes, chronic obstructive pulmonary disease (lung problems), history of cerebrovascular disease (stroke) with dementia, and depression.

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	The clinical record indicated she received physician ordered Lexapro 20 milligrams (mg) one daily by mouth. The Lexapro had a start/order date of 10-11-10. A care plan, dated 7-20-10, with the problem identified as, "Depression AEB [as evidenced by] sad facial expression & loss of spouse." The identified goal was indicated as, "Res [resident] will have [sign for no] S/S [signs and symptoms] of depression QD [daily] TNR [through next review]. The interventions listed for this problem included, "Anti-depressant per order." The care plan failed to include any interventions to assess for side effects for this medication or gradual reduction of dosage when indicated. The clinical record indicated she received physician order enteric-coated aspirin 81 mg daily and this was newly ordered on 8-23-11. A care plan dated 4-22-10 with a discontinuation date of 10-8-10, indicated an identified problem as, "Potential for skin discoloration R/T [related to] ASA [aspirin] use." There was not a current care plan in place for the use of the aspirin. In interview with the Director of Nursing on 9-16-11 at 2:50 p.m., she indicated the care plans for anticoagulants "are not where I would like them to be...but we're working on it." 5. Resident #100's clinical record was			

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	reviewed on 9-16-11 at 9:57 a.m. His diagnoses included, but were not limited to, depression, hypertension (high blood pressure), obesity, diabetes, COPD (chronic obstructive pulmonary disease or lung problems), BPH (benign prostatic hypertrophy or prostate problems), CAD (coronary artery disease or heart problems), and degenerative disc disease (back problems). Additionally, in an interview with the Administrator on 9-16-11 at 2:20 p.m., he indicated Resident #100 was identified as a child sexual predator. Social Services notes, dated 6-30-11, indicated the resident "will be ready for discharge in August [2011]." A Social Services note, dated 7-11-11, indicated the facility planned to appeal the resident's current number of days of approved stay, but if this did not get approved, "will be out by 8-8-11." In review of Resident #100's clinical record, a discharge care planning tool was absent. In interview with the Director of Nursing on 9-16-11 at 2:20 p.m., she indicated, "There is nothing there as far as discharge planning. Normally, that begins at admission." In interview with the current Social Services Designee on 9-16-11 at 11:50 a.m., she indicated, "I don't know the circumstances about the discharge care planning with his admission. I did not see a care plan for			

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	discharge planning. Usually, this would be created upon admission." She indicated she was not employed by the facility at the time of Resident #100's admission. A document entitled, "Careplans," with an activation date of 1-2007 was provided by the Director of Nursing on 9-13-11 at 11:25 a.m. This document indicated the facility policy as, "Each resident will have a plan of care to identify problems, needs and strength [sic] that will identify how the interdisciplinary team will provide care...For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable...Staff approaches are to be developed for each problem/strength need...All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition....Each department's notes are to reflect a review of all appropriate care plan goals and approaches. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure physician orders were followed for adminstration of oxygen for 1 of 17 residents reviewed for care plans in a sample of 17. (Resident #66) Findings include: Review of Resident #66's clinical record on 9-12-11 at 1:40 p.m. indicated her diagnoses included, but were not limited to chronic lung disease, schizophrenia, right above the knee amputation (Feb. 2011), cerebrovascular accident (stroke) with right sided hemiplegia (paralysis), deep vein thrombosis (blood clots) and coronary artery disease (heart problems.) Review of her most current recapitulation orders, September 2011, indicated she was to receive oxygen at 3 liters per minute via nasal cannula continuously due to chronic lung disease. The order for the oxygen was indicated to have been	F0282	F-282 SERVICES BY QUALIFIED PERSON/PER CARE PLANIt is the intent of this facility to ensure physician orders are followed for administration of Oxygen.1. ACTION TAKEN:A. In regards to Resident # 66:The orders were clarified and oxygen was set per orders.2. OTHERS IDENTIFIED:A. 100% audit of all residents receiving oxygen, to ensure orders were being followed. No other residents were identified.3. SYSTEMS IN PLACE:A. All nursing staff were in-serviced/educated on monitoring oxygen settings, notifying the nurse if the liters set is wrong, and following doctor's orders for oxygen administration.4. HOW MONITORED:A. The QA CNA pocket worksheets were updated to reflect all residents utilizing oxygen and the appropriate liters they should be set at. Instructions included to notify nurse if setting is incorrect.B. The IDT will audit twice daily during QA rounds to ensure Oxygen liters are correct for residents utilizing oxygen. This	10/05/2011

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	ordered/activated on 2-26-11. Resident #66 was observed in her room on 9-12-11 at 1:35 p.m., at 2:45 p.m., at 5:50 p.m. and on 9-13-11 at 8:40 a.m. wearing the nasal cannula with the oxygen concentrator indicating the oxygen setting at 2 liters per minute. On 9-13-11 at 9:05 a.m., in interview with the Director of Nursing, she was advised of the current oxygen setting for Resident #66. She indicated, "We'll get that taken care of." On 9-13-11 at 9:22 a.m., the Director of Nursing indicated the oxygen setting was now at the physian-ordered level. 3.1-35(g)(2)		will be an on-going process.C. CEO/Designee will review all audits each day in QA daily stand-up meeting.D. All audits will be reviewed with Medical Director in quarterly QA meeting for review and recommendations.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our completion date is: October 5th 2011.	
F0284 SS=D	When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. Based on interview and record review, the facility failed to obtain a physician's approval or order prior to sending medications home with a resident upon discharge from the facility. This deficient practice affected 1 of 2 residents reviewed for discharges in a sample of 19.	F0284	F-284 ANTICIPATE DISCHARGE: POST DISCHARGE PLAN.It is the intent of this facility to obtain a physician's order prior ro sending medications home with a resident upon discharge from the facility.1. ACTION TAKEN:A. Regarding resident # 100:He is	10/05/2011

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	(Resident #100) Findings include: Resident #100's clinical record was reviewed on 9-16-11 at 9:57 a.m. His diagnoses included, but were not limited to, depression, hypertension (high blood pressure), obesity, diabetes, COPD (chronic obstructive pulmonary disease or lung problems), BPH (benign prostatic hypertrophy or prostate problems), CAD (coronary artery disease or heart problems), and degenerative disc disease (back problems). Review of a document entitled, "Post Discharge to Home Instructions," dated 9-8-11 at 4:15 p.m. and signed by LPN #5, indicated 16 different medications were sent home with Resident #100. Those medications included, Milk of Magnesia, Aspirin 81 milligrams (mg), biscodyl 5 mg, Colace 100 mg, Flovent inhaler, furosemide 40 mg, glipizide 5 mg, imipramine 20 mg, levothyroxine 75 micrograms, lisiniopril 40 mg, Miralax 34 grams, ranitidine 300 mg, simvastin 40 mg, tamsulosin 0.4 mg, Ventolin inhaler, and Tylenol 325 mg. An order from the resident's physician, date 9-8-11, indicated, "May discharge to home 9-8-11." There was no indication		discharged from our facility.2. OTHERS IDENTIFIED:A. 100% audit of all residents discharged in the last 30 days to ensure orders were obtained prior to sending medications home with a resident upon discharge. No other residents were identified.3. MEASURES PLACED:A. All nurses' and social service staff will be in-serviced in regards to discharge planning, and obtaining a physicians order for sending medications home with a resident upon discharge from the facility.4. HOW MONITORED:A. The Unit Manager/Designee will review all discharge orders prior to the actual discharge for inclusion of an order for medications, if necessary. This will be an on-going process.B. DON/Designee will review one discharge chart weekly to review discharge orders for accuracy.C. The CEO/Designee will review all audits as completed in weekly QA stand-up meeting.D. All audits will be reviewed with Medical Director at quarterly QA meetings for futher recommndations.5. This plan of correction constitutes our credible allegations of compliance with all regulatory requirements. Our date of compliance is: October 5th, 2011.	

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	that medications were to be sent home with the resident. In an interview with the Director of Nursing on 9-16-11 at 2:20 p.m., she indicated, "Yes, [I] saw there's no order to sends meds [medications] home with him. Normally, that is there." A policy entitled, "Sending Medication Out of the Facility With the Resident," and a subtitle of "Discharging Resident With Medication," with an original date indicated as 1-1-05 was provided by the Director of Nursing on 9-16-11 at 8:55 a.m. This policy indicated, "Upon receiving discharge orders from the physician, obtain an order to send the appropriate medication home with the resident to avoid a period of unavailable medication." 3.1-36(a)(3)			

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to ensure oxygen therapy was administered in accordance with physician orders for 1 of 17 residents reviewed for oxygen therapy in a sample of 17. (Resident #66) Findings include: Review of Resident #66's clinical record on 9-12-11 at 1:40 p.m. indicated her diagnoses included, but were not limited to chronic lung disease, schizophrenia, right above the knee amputation (Feb. 2011), cerebrovascular accident (stroke) with right sided hemiplegia (paralysis), deep vein thrombosis (blood clots) and coronary artery disease (heart problems.) Review of her most current recapitulation orders, September 2011, indicated she was to receive oxygen at 3 liters per minute via nasal cannula continuously due to chronic lung disease. The order for the oxygen was indicated to have been	F0328	F-328 TREATMENT/CARE FOR SPECIAL NEEDSIt is the intent of this facility to ensure physician orders are followed for administration of oxygen.1. ACTIONS TAKEN:A. In regards to resident #66:The orders were clarified and the oxygen was set per orders.2. OTHERS IDENTIFIED:A. 100% audit of all residents receiving oxygen, to ensure orders are being followed. No other residents were identified.3. SYSTEMS IN PLACE: A. All nursing staff were in-serviced/educated on monitoring oxygen settings, notifying the nurse if the liters set is wrong, and following doctor's orders for oxygen administration.4. HOW MONITORED:A. The QA CNA pocket worksheets were updated to reflect all residents utilizing oxygen and the appropriate liters they should be set at. Instructions included to notify nurse if setting is incorrect.B. The IDT will audity twice daily during QA rounds to ensure Oxygen	10/05/2011

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	ordered/activated on 2-26-11. Review of the current "Respiratory Medication Flow" form for September 2011 indicated for 9-1-11 through 9-13-11, the resident was receiving 3 liters per minute of oxygen via nasal cannula continuously for a diagnosis listed as chronic lung disease. Resident #66 was observed in her room on 9-12-11 at 1:35 p.m., at 2:45 p.m., at 5:50 p.m. and on 9-13-11 at 8:40 a.m. wearing the nasal cannula with the oxygen concentrator indicating the oxygen setting at 2 liters per minute. On 9-13-11 at 9:05 a.m., in interview with the Director of Nursing, she was advised of the current oxygen setting for Resident #66. She indicated, "We'll get that taken care of." On 9-13-11 at 9:22 a.m., the Director of Nursing indicated the oxygen setting was now at the physician-ordered level. 3.1-47(a)(6)		liters are correct for residents utilizing oxygen. This will be an on-going process.C. CEO/Designee will review all audits each day in QA daily stand-up meeting.D. All audits will be reviewed with Medical Director quarterly QA meeting for review and recommendations.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our completion date is: October 5th, 2011	

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	155209	A. BUILDING 00 B. WING	09/19/2011

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to: - Include the payor source on a discharged resident's face sheet (Resident #101), - Ensure a resident's inventory sheet was signed upon discharge (Resident #102), and - Ensure medication orders were accurately transcribed on recapitulation orders for the following month. (Resident #64) This affected 3 of 19 residents reviewed for complete and accurate records in a sample of 19. Findings include: 1. Resident #101's closed record was reviewed on 9/16/11 at 12:12 p.m. The record indicated Resident #101 was admitted on 5/17/11 and discharged on 7/26/11, with diagnoses that included, but	F0514	F514 CLINICAL RECORDS:The intent of the facility is for all residents to have a completed face sheet including the payor source; to have the inventory sheet signed by the resident/responsible party upon admission and discharge; and that the recapitulations of orders is accurately transcribed.1. ACTIONS TAKEN:A. In regards to resident #101: this resident is no longer in our facility.B. In regards to resident #102: this resident is no longer in our facility. C. In regards to resident #64: the resident health record has been updated to reflect all current orders.2. OTHERS IDENTIFIED:A. BOM/Designee will complete a 100% audit of all resident health records for complete/accurate face sheet with inclusion of payor source. Any identified will be immediatly updated to reflect current information.B. Medical Records/Designee will complete a 100% audit of all resident health records of residents who were	10/05/2011

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	were not limited to, enlarged heart, heart disease with stent placement, diabetes, and acute exacerbation of chronic obstructive pulmonary disease. A face sheet with a printed date of 5/18/11 failed to include the billing information that would have included the payor source. During an interview on 9/19/11 at 12:35 p.m., the business office supervisor indicated the billing information should have been on there, they get the information and update it on the face sheet after admission. 2. Resident #102's closed record was reviewed on 9/19/11 at 10:03 a.m. The record indicated Resident #102 was discharged on 8/1/11. An inventory sheet that listed the resident's personal effects had not been signed upon discharge to indicate the resident/family had received their property. During an interview on 9/19/11 at 5:28 p.m., the Director of Nursing (DON) indicated the resident had been sent to a hospital and did not return to this facility upon discharge from the hospital. She further indicated the family did pick up		discharged in the last 30 days for the signature of the resident/responsible party on admission/discharge. Any that are not signed will have a copy mailed to the resident/responsible party for signature.C. Medical Records/Designee will complete a 100% audit of all current resident health records for signature by resident/responsible party. Any not signed will be presented to the resident/responsible party for signature.3. SYSTEMS IN PALCE:A. In-service all responsible departments on the importance of current information, complete/accurate information, and the importance of an accurate recapitulation of all MD orders.4. HOW MONITORED:A. Medical Records/Designee will audit all new admisisons for appropriate signature on inventory sheets. This will be an on-going process.B. DON/Designee will audit all recapitulation of MD orders for accuracy as delivered by the pharmacy. This will be an on-going process.C. CEO/Designee will review all audits as completed and will review in the daily QA stand-up meeting; monthly in the QA meeting; and quarterly in QA meeting with Medical Director. This will remain an on-going audit.5. THIS PLAN OF CORRECTION CONSTITUTES OUR CREDIBLE ALLEGATION OF COMPLIANCE WITH ALL	

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	the personal items, but did not sign the inventory sheet when they were in the facility. The DON also indicated the inventory sheet had not been mailed to the family for a signature. 3. Review of Resident # 64's clinical record on 9-15-11 at 10:40 a.m., indicated her diagnoses included, but were not limited to coronary artery disease (heart problems), hypertension (high blood pressure), diabetes, chronic obstructive pulmonary disease (lung problems), history of cerebrovascular disease (stroke) with dementia, and depression. A physician telephone order, dated 8-23-11 at 9:00 p.m., indicated, "D/C [discontinue] Omeprazole. Start EC [enteric coated] ASA [aspirin] 81 mg [milligrams] po [by mouth] QD [every day]." The recapitulation (recap) orders for September 2011 were signed as reviewed by an illegible facility staff signature on 8-31-11. The above telephone order, dated 8-23-11, for discontinuing omeprazole and beginning the aspirin were not included on the recap orders. However, an order for an antibiotic, Avelox, with a start date indicated as 8-25-11, was included on the recapitulation orders.		REGULATORY REQUIREMENTS. OUR DATE OF COMPLIANCE IS: OCTOBER 5TH, 2011	

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In interview with the Director of Nursing on 9-16-11 at 2:50 p.m., she indicated she was unsure why the September 2011 recapitulation orders did not reflect the aspirin and omeprazole orders from 8-23-11, but reflected the orders from 8-25-11 for the antibiotic. She indicated the Medication Administration Record (MAR) did reflect the correct orders for the aspirin and omeprazole.

A document entitled, "Recapitulation of Computerized Pharmacy Records," with a revision date of 5-1-10, was provided by the Director of Nursing on 9-16-11 at 8:55 a.m. This document indicated, "Corrections, additions, and changes to the computerized medical record should by made by a licensed nurse, Facility medical records staff, or an authorized designee. The original order date should accompany written entries...Changes...should be made...when such documentation is required. Facility staff members who make hand-written changes...should sign and date all entries..."

A document entitled, "Medical Records," with an effective date of 4-06 was provided by the Director of Nursing on 9-19-11 at 11:58 a.m. This document indicated, "Each resident will have an

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	active medical record. This resident record shall be kept current, complete, legible, and available at all times to authorized personnel." 3.1-50(a)(1) 3.1-50(a)(2)			